NHS Dorset Clinical Commissioning Group

Clinical Risk Framework

Supporting people in Dorset to lead healthier lives

1.0 **Introduction**

1.1 The Clinical Services Review (CSR) is being led by the NHS Dorset Clinical Commissioning Group (CCG). The CCG is the organisation responsible for commissioning – or planning and securing – healthcare in Dorset. The proposals within the CSR are ambitious and forward thinking. They include large-scale changes to health and care services in both community and hospital settings.

1.2 The mental health Acute Care Pathway ACP Review has been led by the CCG and fully coproduced and has run alongside the CSR. The ACP proposals are also ambitious and innovative and include additional services with a focus on prevention and early help.

1.3 The scale of both reviews meant that it was important that the CCG heard views from the public on how our community services and acute hospitals might be delivered differently to provide safe, high-quality care in Dorset for now and the future. The CCG has said what its preferred options are for both acute hospitals and community services. The reason for this was to give a better understanding of how services in Dorset could look in the future and what this could mean for people, personally. The MH Acute Care Pathway also had a preferred option because it met all of the coproduced objectives.

1.4 A formal public consultation ran for 12 weeks from December 2016. Whilst the formal evaluation of consultation responses is underway some initial analysis of responses has identified the following themes:

- Clinical risk, impact of travel, particularly in maternity, paediatric and emergency care specialties.
- Rural access to key services of maternity, paediatrics, emergency services and community beds
- Particular concerns over removal of beds in Shaftesbury
- Maternity and paediatrics configuration with Poole/Bournemouth and Yeovil; travel, safety and visiting issues.

1.5 The MH ACP public consultation ran from beginning of February to the end March 2017 and the evaluation of responses highlights similar concerns about public transport especially in the rural parts of the county there were also concerns about the closure of the Linden Unit and whether or not the proposed number of beds will provide enough female beds in the west of the county.

1.6 The aim of this document is therefore to provide a framework to consider the above identified issues and specifically focus on identifying any associated potential clinical risks and to provide assurance that the Clinical Services Review has considered, and will continue to consider, clinical risk and, where identified, how these risks would be mitigated.

1.6 This document should be read in conjunction with the CSR Benefits Framework, which highlights the health and wellbeing, care and quality and financial benefits of the CSR.

1.7 Clinical risk has been considered throughout the development of the CSR proposal, this has been achieved through Clinical Working Groups which met on numerous occasions and involved clinicians from a variety of health settings. The Wessex Clinical Senate have also been involved through the CSR and formed part of the CCG assurance process to proceed to consultation.

1.8 The limitations of this Framework are that for some services the details in proposed changes are not yet clear and therefore more in depth assessment of risk will be undertaken as more

clarity around specific services are identified. This will include full details of clinical risk assessments.

2.0 Maternity Services and Children's Services

2.1 The CSR recommendation for maternity and paediatric services was for a new maternity and women and children's unit at the major emergency hospital. This would provide a maternity unit for women deemed as high risk pregnancy, inpatient consultant delivered services for very sick children, a local neonatal unit for babies delivered under 32 weeks and all of these services provided 24 hours a day.

2.2 This would mean that at the proposed planned site there would be antenatal care and children's therapies and at Dorset County Hospital there would be services integrated with Yeovil OR part of the Dorset wide network with a move to midwifery led unit and paediatric assessment unit.

2.3 The predominant clinical risk with each of these proposed services relates to the travel time from particularly areas in West of the County.

2.4 The Royal College of Paediatrics and Child Health independent review of local current services highlighted the advantageous to clinical outcomes with proposed reconfigurations.

Maternity Services

2.5 Maternity services may be provided in Dorset from a midwifery led unit in one end of the County and from a consultant led unit on the emergency site. This risk is mitigated by providing increased training for staff; developing skills of midwives so that Midwifery led care is associated with fewer complications and fewer interventions during labour including early decisions about recognitions of problems.

2.6 It is expected that women will be offered a choice of where to have their baby. Whilst it is expected that the majority of women who are also deemed "low risk" would choose to give birth at home or in the closest midwifery led unit, some women may choose to give birth in a consultant led unit, which for some women will mean that transport to give birth is requested from the ambulance service. The ambulance service will also need to be available to transfer the small number of women who would require transfer in labour. To mitigate this risk a midwife and or anaesthetist at least would be expected to travel with the woman in labour.

2.7 The National Perinatal Epidemiology Unit (NPEU) reports were submitted to the BETTER BIRTHS improving outcomes of maternity services review in England (2015). The key findings of this report identified that overall, midwifery style services can provide good care for low risk women having a second or subsequent baby. Planning a birth at home or in a midwifery unit results in fewer interventions, the chances of transfer are low, and there is no evidence that outcomes are worse.

2.8 The woman's ethnicity and the level of deprivation where she lives make no difference, although the chances of transfer increase according to her age. Moreover, freestanding midwifery units appear comparable with midwifery led units alongside consultant led units: there is no evidence that outcomes are worse for babies, and women who plan births in freestanding units have a lower likelihood of intervention.

2.9 In addition, trusts which supported more home births achieved better maternal outcomes compared with trusts which supported fewer home births. The picture is slightly different for low risk women having their first baby. Overall, such women planning births at home or in

midwifery units have fewer interventions, but there is a higher risk of transfer and with home births a small increased chance of an adverse outcome for the baby.

Paediatric Services

2.10 The clinical risk associated with the development of a network approach to Paediatrics would be a loss of inpatient beds and associated staff.

2.11 From the CSR proposals it is not yet clear exactly what services would be provided from Dorset County Hospital site, the assessment of any associated clinical risks is therefore based on the CSR proposal for an assessment unit only. This would require children to travel to the major emergency hospital site for admission and with a reduction in clinical expertise at Dorset County site may result in additional transfers for assessment.

2.12 Again the mitigation for this risk would be through a readily available ambulance service that could either convey directly to the major emergency hospital or could transfer from the other emergency department and urgent care centres across the county. This is likely to also require suitably trained staff to escort the child during the transfer.

3.0 Community Hospitals and removal of community beds

3.1 There are currently 13 community hospitals within Dorset, most with beds. The CSR proposed to change some of the community hospitals to community hubs without beds.

3.2 The result of the analysis of community hospitals showed that if there were seven strategically located sites with beds compared with 12 at present: 100% of people would be able to reach proposed community bedded sites within 32 minutes by private car, and 87% within one hour by public transport and 100% of people would be able to reach a community hub (with or without beds) in 23 minutes by private car, and 91% within one hour by public transport.

3.3 The clinical risks associated with this proposal will be largely determined once the final locations of bedded hubs are agreed. As with other services in the review risks are associated with transport times, however it is not envisaged that acutely unwell people will be cared for on these sites.

3.4 The reduction in bedded hubs could be considered a reduction in clinical risks as this would be develop improved health professional support.

4.0 Urgent Care

4.1 The major hospital site would provide a consultant delivered Accident and Emergency service 24 hours per day. A consultant led A&E would be provided at Dorset County Hospital and an Urgent Care Centre provided from the major planned site. This would mean that there would be some people living near the planned hospital site who may need to travel further than currently to the major emergency site. The mitigation for this would be that in the most serious and life threatening situations people would be taken to the relevant emergency department by ambulance with suitably trained and experienced paramedic staff.

4.2 The development of a successful major emergency department in the East of the County will clearly increase demand not only through this department but also the rest of the hospital. The risk associated with this is that the flow from the emergency department is decreased if the system is not able to promote early and successful discharge. This links closely with work in all other areas of the clinical services review to ensure that identification of need is based

upon a shift of assessment from acute hospitals to community, urgent or primary care services.

4.3 With the proposed move to a planned and emergency site there is further work required to understand the extent of medical emergency take on the planned site, which in turn will require an assessment of the support available to this site in the event of an emergency.

4.4 It is recognised that there are currently a number of transfers that take place between the two hospitals in the East of the County, however the impact of these proposed changes will need to re-assess the likelihood and frequency of transfers and agree a planned approach to identify a provider to undertake this work.

4.5 Urgent treatment centres have been proposed through the review and the risks associated with these are that people may self-present to these units and their condition is so serious that it cannot be safely managed in these areas. This risk currently exists at the various minor injuries units in the County and therefore mitigation of this risk should be addressed through clear and comprehensive public and professional communication of the service offer.

4.6 It is important to reference the Keogh report on urgent and emergency care services (2013) which sets out the advantages of the proposed models of care in terms of reducing clinical risk.

5.0 Acute Services

Critical Care

5.1 There are a number of acute services that currently work on a dedicated site or work across a network and it is proposed that this extends through the CSR to other areas.

5.2 One area identified as presenting significant changes to current provision is critical care services. At present both hospitals in the East of the County have critical care units. The current environments both require updating. There are also issues in attracting staff to work in these areas. It is suggested that working in a network with a larger unit would be more likely to attractive staff to work in this area.

5.3 The critical care services currently work in a network approach and transferring people to the most appropriate unit happens now. Under the proposals the requirement for transfer of patients will still exist and this may be particularly if a person on the planned site deteriorates and require transfer to the emergency centre. This risk and required mitigation aligns with that identified in bullet point 4.4 above.

Cancer Services

5.4 The proposal for cancer services would see outpatients, end of life and acute assessment in three locations; Dorset County Hospital; Poole Hospital and Bournemouth hospital.

5.5 There are some conditions, most obviously spinal cord compression and neutropenic sepsis that require inpatient admission. The pathways for people with these conditions will require further detailed work as the requirement for radiotherapy needs to be considered.

5.6 The risks evident in these service areas are associated with workforce working across more than one site, and again urgent transfer between sites.

6.0 Mental Health Acute Care Pathway Review

6.1 The proposal for acute mental health services is to add some services that will enable people who live with serious mental illness to access help sooner so that where possible crisis do not develop. The proposal is to:

- Create two Retreats one in Bournemouth and one in Dorchester
- Enhance the crisis line and create the Connection service that will have additional staff to support people when they call including online and SKYPE
- Create three community front rooms in the west of the county
- Re-commission seven recovery beds split between east and west of the county
- Increase the overall number of inpatient beds in the county by 16, 12 new beds will go to St Ann's and 4 new beds will go to Forston Clinic.
- The Linden Unit will be closed and the 15 beds redistributed to St Ann's Hospital

6.2. The aim of the inpatient bed changes is to reduce the use of out of area placements by making sure that the majority of people can access an inpatient bed within 31 miles and as far as possible to make sure that most patients who require an inpatient stay can, wherever possible go to the inpatient unit closest to them.

6.3 Risks highlighted from the consultation and to be addresses during the development of a business case relate to:

- Travel specifically the reduction in public transport for certain routes particularly in the west of the county
- The safe staffing of the Retreats and Community Front Rooms
- The closure of the Linden Unit specifically related to ensuring that there are the right number of male and female beds east and west of the county

7.0 Conclusion

7.1 A key risk that has been identified in the majority of service areas is associated with either transport or transfer and further work will be required to determine the safest way to address this matter.

7.2 Whilst the report focuses on clinical risk associated with potential changes in service delivery, it must be recognised that services as they are currently configured also pose some clinical risks. In broad terms some services are so small as to provide challenges in maintaining clinical competence and because of this difficulty in attracting and retaining staff.

7.3 This document has outlined key high level clinical risks in relation to proposed changes under the Clinical Services Review. It is acknowledged that there is further work required to identify risks that will be specific to each service as the implementation plans are developed and this risk document will therefore be updated as these plans emerge. These plans will focus on clinical risks against both current and proposed services at specialty level. Perhaps most importantly will be the requirement to assess service level implementation plans alongside one another as the co-dependencies between services must be understood to ensure that the change to one service is not detrimental and therefore increases clinical risks.

7.4 Mitigating actions for all areas of risk identified will continue to be put in place and closely monitored throughout the transition process.